EXHIBIT 10

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION

STATE OF MISSISSIPPI; STATE OF ALABAMA; STATE OF ARKANSAS; COMMONWEALTH OF KENTUCKY; STATE OF LOUISIANA; STATE OF Missouri; and STATE OF MONTANA,

Plaintiffs,

v.

XAVIER BECERRA, in his official capacity as Secretary of Health and Human Services; THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CHIQUITA BROOKS-LASURE, in her official capacity as Administrator of the Centers for Medicare and Medicaid Services; THE CENTERS FOR MEDICARE AND MEDICAID SERVICES; THE UNITED STATES OF AMERICA,

Defendants.

No. 1:22-cv-113-HSO-RPM

DECLARATION OF DR. SIDNEY CALLAHAN

I, Dr. Sidney Callahan, declare as follows:

1. The facts set forth in this declaration are based on my personal knowledge, and if called as a witness, I could and would competently testify to the following matters under oath.
2. I am a board-certified Obstetrician-Gynecologist at Green Valley OB/GYN, a private practice that is owned by Unified Women's Health—a single specialty group with practices across multiple states. I joined Green Valley after graduating from the University of New England College of Osteopathic Medicine and completing my residency at Abington

Memorial Hospital in Abington, Pennsylvania. While attending the University of New England, I also obtained a master's degree in Public Health from Johns Hopkins University in Baltimore, Maryland.

3. I work with a very diverse range of patients. Nearly half of my patients are Black. A number of my patients speak English as a second language. And the ages of my patients range from teenagers to 90-year-olds. Some of my older patients rely on Medicare as their sole source of medical insurance.

4. I am familiar with the concept of disparity in health care outcomes because of the academic focus of my graduate education and the range of experiences I have had while practicing medicine in Greensboro, North Carolina. In my view, disparity in health care refers to differences in medical outcomes that patients experience even though they share the same underlying medical condition.

5. During my graduate program, I spent a substantial amount of time studying global health disparities. My interest in addressing global health disparities led me to provide voluntary medical care in several different countries. For example, I spent three years volunteering with a project in Cap-Haïtien, Haiti that strives to reduce maternal mortality. Most recently, I spent three weeks in Nepal to help develop a health care system in the Himalayas. I have also provided voluntary medical care in Uganda and India.

6. I became more familiar with racial disparities in health care when I moved to Greensboro, North Carolina and began practicing medicine at Green Valley OB/GYN. My time in Greensboro has been an awakening in how much work remains to be done in reducing health disparities that people of color, particularly Black people, experience in communities across the United States.

7. I became a member of the Greensboro Health Disparity Collaborative to support community efforts toward reducing racial disparity in health care throughout Greensboro, North Carolina. I first learned about the Collaborative through a guest speaker who came to Moses Cone Hospital to discuss the Collaborative's work. The Collaborative's mission is to establish structures and processes that respond to, empower and facilitate communities in defining and resolving issues related to disparities in health. As a member of the Collaborative, I attend monthly meetings and participate in the Collaborative's research, fundraising, and other programing efforts. I have been a member of the Collaborative for nearly three years.

8. As a prerequisite to membership in the Collaborative, I participated in "Phase 1" of the Collaborative's anti-racism training program. The training involved a two-day seminar where a facilitator led a small group (approximately 20 people) through range of exercises to identify and discuss people's perceptions of race. The facilitator also explained how policies throughout the United States' history have diminished Black Americans' access to resources and opportunities in an ongoing, systemic way. For example, the facilitator explained how low rates of Black home ownership today are a modern byproduct of decades of redlining.

9. I have attended the Collaborative's Phase 1 training multiple times and believe that it has had a positive effect on the way that I practice medicine. The lessons I learned about structural racism and cultural differences provide me with a reminder that, because of the implicit biases we all have, simply ignoring the race of my patients may actually lead to racially disparate health outcomes. For example, I have worked with Black patients who have vocalized their suspicion toward medicine and medical professionals. If I ignore the

historical reasons why a Black person in America may be suspicious of medical providers, I lose trust with my patient and hinder my ability to design a treatment plan that my patient is likely to complete.

10. I think that medical professionals would provide better care to *all* of their patients if they participated in anti-racism training. In my experience, the vast majority of doctors believe they provide equal care to all of their patients, regardless of race. But I have observed some of those same providers discuss or complain about their patients using racial stereotypes. For example, I have heard providers disparage Black patients who own expensive sneakers or other accessories but have not spent money on preventative health care measures. I have frequently encouraged my colleagues to participate in anti-racism training because I believe that this training teaches empathy for and understanding of the many reasons why people of color may be reluctant or unable to engage with providers of routine, preventative medical care.

11. Anti-racism training is particularly important for medical professionals who serve Medicare recipients. Older people of color who are eligible for and aging into Medicare are most likely to have suffered from some of the most extreme forms of overt racism, including at the hands of medical professionals. If healthcare providers ignore how those experiences may have influenced their patient's medical history, they cannot develop a treatment plan that fully suits their patient's needs.

12. I do not provide worse medical care to white patients because I have participated in the Collaborative's anti-racism trainings or because I am sensitive to the distinct needs of my patients of color. In fact, the Collaborative recently completed a five-year study in connection with the University of North Carolina at Chapel Hill, The Partnership Project,

Inc., Cone Health, and the University of Pittsburgh Medical Center which showed that implementing various anti-racism measures improved outcomes for *all* patients with Stage 1 or 2 breast or lung cancer. The results of this study, Accountability for Cancer Care Through Undoing Racism and Equity (ACCURE), also fortify my belief that encouraging doctors to participate in anti-racism training is not tantamount to "reverse racism"—the concept that being mindful of and attempting to eliminate implicit bias against Black people will necessarily result in discrimination against white people. The Collaborative applied for and obtained a grant for this study from the National Cancer Institute, which is part of the National Institutes of Health.

13. My practice is collaborating with UNC to complete a follow-on study to the ACCURE. The study, called ACURE4Moms will examine whether implementing anti-racism measures in the obstetrics and gynecology context will similarly eliminate racial health disparities and improve health care outcomes for all patients.

14. A critical part of the Collaborative's mission is to encourage as many health care providers as possible to understand the importance of addressing racial disparities in health care and to help them develop approaches and methods to accomplish that goal. If Medicare providers have an option to adopt anti-racism plans as part of the Merit-Based Incentive Payment System, this will help us accomplish our mission. On the other hand, if that option is prohibited, this will present an obstacle and force us to find other ways to persuade health care providers to adopt plans without government support and encouragement. In short, it will make our mission more difficult and indeed, more expensive, as we work with health care providers and encourage them to acknowledge and address the impact of race on providing the highest level of medical care.

I solemnly swear and affirm under the penalties of perjury that the foregoing is true and correct based on my personal knowledge.

/s/ Sidney Callahan
Declarant's Signature

5/11/2023
Date

Sidney Callahan
Declarant's Printed Name